LTC/STC/Hybrid Health Pre-Screen

Phone: (800) 842-7799
Fax: (866) 863-8608

Agent Information

Agent Name:	Agent Phone Number:	Agent Email Address:

Proposed Policy

Monthly Benefit:	Benefit Duration:	Riders Requested:	Resident State:
			Partnership: Yes ◯ No ◯

Client Information

Client's Name: _____

State: _____

◯ Male ◯ Female

DOB: ___/___/____ Height: _____ Weight: _____

Tobacco User: ◯ Yes ◯ No

If so, please indicate the type and frequency. If quit, indicate last use.

_____

Does the client have a spouse or significant other with whom they reside?

◯ Yes ◯ No

Medical Questions

Have you ever been diagnosed with or treated for one of these conditions? (check all that apply)

- ☐ Diabetes requiring Insulin
- ☐ Peripheral Vascular Disease
- ☐ Carotid Artery Disease
- ☐ Skin Ulcers
- ☐ Stroke or Transient Ischemic Attack (TIA)
- ☐ Alzheimer's Disease, Lewy Body Disease, or Dementia
- ☐ Psychosis or Schizophrenia
- ☐ Mental Retardation
- ☐ Amyotrophic Lateral Sclerosis (ALS) or Myasthenia Gravis
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease or Parkinsonism
- ☐ Post-Polio Syndrome
- ☐ Demyelinating Disease
- ☐ Lupus (SLE)
- ☐ Mixed Connective Tissue Disease
- ☐ Scleroderma
- ☐ Muscular Dystrophy
- ☐ Amputation-Due to Disease
- ☐ Double Heart Valve Replacement
- ☐ Organ or Bone Marrow Transplants
- ☐ Kidney Disease or Polycystic Kidney Disease
- ☐ Cirrhosis of the Liver
- ☐ Hepatitis B, C, D or E
- ☐ Hemachromatosis
- ☐ Metastatic Cancer
- ☐ Multiple Myeloma
- ☐ Brain or Spinal Cord Tumors
- ☐ AIDS
- ☐ Neurological Conditions affecting the brain or spinal cord
- ☐ Muscular Conditions Causing Functional Limits

Medications

☐ Check here if you DO NOT TAKE ANY MEDICATIONS

Record all medications you currently take including **prescription medications** and any **over the counter drugs**.

Name of Drug	Dosage	Frequency	When Prescribed	Reason for Taking

Have you been prescribed any medications you are not taking?

◯ Yes ◯ No If yes - provide details (i.e. name of medication, who prescribed, for what condition, why not taking it: _____

_____

Do you have any surgeries planned or recommended?

◯ Yes ◯ No Provide details of Type of Surgery and when it is scheduled: _____

_____

When was the last time you saw your primary physician and why?

Date Last Seen: _____

Reason: _____

_____

List any specialists you have seen in the last 5 years.

Type of Specialist:	Month/Year last seen:	Reason for Visit:
1.		
2.		
3.		

Have you ever been on disability?

◯ Yes ◯ No Provide details: _____

_____

Do you have a handicapped parking tag?

◯ Yes ◯ No If yes, why? _____

_____

Have you ever been turned down for any insurance coverage?

◯ Yes ◯ No If yes - give type of insurance, date and reason: _____

_____

Cancer History

Type: _____

Date Diagnosed: _____

Treatment: _____

_____

Stage: _____

Grade: _____

Lymph Node Involvement: ◯ Yes ◯ No

Date of Last Treatment: _____

Any Recurrence? ◯ Yes ◯ No

If prostate cancer, please include pre-PSA: _____

current PSA: _____

Gleason Score: _____

Diabetes History

◯ Type I ◯ Type II

Date Diagnosed: _____

Medications: _____

A1C: _____

Any Complications (retinopathy, neuropathy, nephropathy): _____

_____

Heart Disease History

Heart Attack: ◯ Yes ◯ No

If yes, please provide date(s): _____

_____

Stroke: ◯ Yes ◯ No

If yes, please provide date(s): _____

_____

TIA: ◯ Yes ◯ No

If yes, please provide date(s): _____

_____

Bypass Surgery? ◯ Yes ◯ No

- If yes, please provide date(s): _____

Angioplasty? ◯ Yes ◯ No

- If yes, please provide date(s): _____

Pacemaker? ◯ Yes ◯ No

- If yes, please provide date(s): _____

Defibrillator? ◯ Yes ◯ No

- If yes, please provide date(s): _____

Sleep Apnea History

Date Diagnosed: _____

Severity / AHI events per hour: _____

CPAP, BiPAP, dental device use: ◯ Yes ◯ No Frequency: _____

Mental Illness/Depression History

Name of condition: _____

Date Diagnosed: _____

Severity: _____

Treatment: _____

_____

Seeing a psychiatrist/psychologist? _____

Attempted suicide? If yes, date(s): _____

Hospitalization due to depression? ◯ Yes ◯ No

Lung Disorder History

Type of Disorder (asthma, bronchitis, COPD, emphysema, etc.):

_____

_____

_____

Treatment: _____

Severity: _____

Frequency of attacks: _____

Dates of hospitalizations/ER visits: _____

Bone, Joint, or Muscular Problems:

1. Surgery/joint replacements or recommended surgery in the past 5 years? ◯ Yes ◯ No
2. Any history of joint injections in the last 5 years? ◯ Yes ◯ No
3. Do you have any joint deformities? ◯ Yes ◯ No
4. Are you currently in physical therapy or using any medical equipment (i.e. cane, walker, crutches)? ◯ Yes ◯ No

To the best of your knowledge, has your biological mother, father or sibling been diagnosed with coronary heart disease or any form of dementia (e.g. Alzheimer's Disease)?

Family Member:	Condition:	Age of Diagnosis:
1.		
2.		
3.		

Additional Information

Please include any Health History that was not covered in above areas. Also, include any additional information that you may have regarding the above areas. If this is a rush, please indicate when needed by. For certain risk assessments, we are at the mercy of the carriers to get back to us. Please allow extra time so we can find you the best carrier given the information provided.

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Prescreen submissions will be answered within 4 hours. Any submitted after 5 p.m. will be answered early the following morning.

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